SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SIP-1 Fixed Indemnity Policy*		
Project Name/Number:	*SIP-1 Fixed Indemnity Policy/*		

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: SIP-1 Fixed Indemnity Policy	SERFF Tr Num: RNIC-125859625	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 40586
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Kyle Conrad, Brenda Ingram	Disposition Date: 10/17/2008
	Date Submitted: 10/16/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: SIP-1 Fixed Indemnity Policy	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/17/2008	
State Status Changed: 10/17/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

October 16, 2008

Ms. Rosalind D. Minor

Certified Rate and Form Analyst

Life and Health Division

Arkansas Insurance Department

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
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1200 West Third Street

Little Rock, AR 72201-1904

RE: Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453

Form SIP-1 – Fixed Indemnity Policy

Form SIP-SURG-2 – Surgical Benefit Rider

Form SIP-SURG-3 – Surgical Benefit Rider

Form UAP-1 AR (1/09) – General A&H Application

Form OC SIP-1 AR – Outline of Coverage

Form RP-A&H – Notice to Applicant Regarding Replacement

Dear Ms. Minor:

We are submitting the above-referenced forms, which we request you consider for approval. This is a new filing not previously submitted.

Form SIP-1 provides the following fixed indemnity benefits as described in the policy: Hospital Confinement Benefit, Inpatient Doctor Visits Benefit; Outpatient Doctor Visits Benefit; Prescriptions, X-Rays and Lab Tests Benefit; Home Health Care Benefit; and Home Health Care Aide Benefit

There will be two Surgical Benefit Riders available on an optional basis, both of which provide the following benefits as described in the riders: Surgeon's Benefit; Anesthesia Benefit; and Outpatient Facility Benefit. These two riders are identical, except that under Surgical Benefit Rider Form SIP-SURG-2 the maximum Surgeon's Benefit is $2,000 and under Surgical Benefit Rider Form SIP-SURG-3 the maximum Surgeon's Benefit is $3,000.

Form SIP-1 will be available to individuals age 0 through 64. It will not be available to individuals who are 65 or older.

The following forms to be used with Form SIP-1 are also enclosed:

1. Form UAP-1 AR (1/09) – General A&H Application will be used as the application for Form SIP-1. Form UAP-1 AR (1/09) will also be used as the application for other accident and health policies previously approved by your office.

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
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Product Name:	*SIP-1 Fixed Indemnity Policy*		
Project Name/Number:	*SIP-1 Fixed Indemnity Policy/*		

2. Form OC SIP-1 AR – Outline of Coverage, which will be used in connection with each application for Form SIP-1.

3. Form RP-A&H – Notice to Applicant Regarding Replacement, which will be used in replacement situations. This form was previously approved by your office.

We are also submitting the rates and a supporting actuarial memorandum related to this filing.

If this filing meets with your approval, please provide us with appropriate evidence thereof.

Thank you for your consideration in this matter. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

Sincerely,

Kyle D. Conrad
Senior Vice President
and Associate Corporate Counsel

Company and Contact

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel	kconrad@unitrin.com	
6100 N. W. Grand Blvd Oklahoma City, OK 73118	(800) 874-1431 [Phone]	

Filing Company Information

Reserve National Insurance Company 6100 N.W. Grand Boulevard Oklahoma City, OK 73118 (405) 848-7931 ext. 549[Phone]	CoCode: 68462 Group Code: 215 Group Name: Reserve National FEIN Number: 73-0661453 ---------	State of Domicile: Oklahoma Company Type: Life and Health State ID Number:

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
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Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	Policy = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	$50.00	10/16/2008	23223004

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
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Product Name:	*SIP-1 Fixed Indemnity Policy*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/17/2008	10/17/2008

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
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Disposition

Disposition Date: 10/17/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Fixed Indemnity Policy	Approved-Closed	Yes
Form	Notice to Applicant Regarding Replacement	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
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Form Schedule

Lead Form Number: SIP-1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SIP-1	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Fixed Indemnity Policy	Initial		82	SIP-1_POLICY_AR.pdf
Approved-Closed	RP-A&H	Other	Notice to Applicant Regarding Replacement	Other	Other Explanation: Previously Approved		RP-A&H.pdf

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
THIS IS A FIXED INDEMNITY POLICY THAT PROVIDES A STATED BENEFIT AMOUNT FOR COVERED TREATMENT OF A COVERED PERSON'S INJURY OR SICKNESS. COVERAGE UNDER THIS POLICY IS RENEWABLE AS PROVIDED IN THE RENEWAL SAFEGUARD PROVISION. PREMIUMS ARE BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.

Reserve National INSURANCE COMPANY

6100 NORTHWEST GRAND BLVD. - OKLAHOMA CITY, OKLAHOMA 73118-1082

When we use "we," "us," or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean a Covered Person as defined in this Policy and as named on the Insured Schedule.

Reserve National Insurance Company agrees to indemnify the Covered Person(s) as hereinafter provided, subject, however, to all the provisions, conditions, exclusions, limits of liability and other terms in this Policy.

INSURING AGREEMENT

In consideration of the payment of the premium in advance and in reliance upon the statements in your application, a copy of which is attached and which forms a part of this Policy, we hereby insure the person(s) named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where you reside, on the Effective Date shown on the Insured Schedule. The initial premium is for the policy term shown on the Insured Schedule. The renewal premium for later policy terms is due on the first day of the next policy term. The coverage provided by this Policy will cease if the renewal premium in effect is not paid when due or within the grace period. Each policy term will begin and end at 12:01 A.M., Standard Time, at the place where the Insured resides.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company at 6100 Northwest Grand Blvd., Oklahoma City, Oklahoma 73118-1082, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

You are granted a period of 10 days from the date of delivery of this Policy to examine it. If you are not satisfied for any reason, this Policy may be returned within said 10 days to the Company at its Home Office or to the writing agent. Then the Company shall refund the premium paid, this Policy shall be void from its beginning, and you and Reserve National shall be in the same position as if it had never been issued.

PREMIUMS ARE SUBJECT TO CHANGE

Premiums are subject to change as provided in the Premium Payments provision. No change in premium will be effective before the first Policy anniversary. Any change will apply to future premiums for all policies with the same form number issued by us to individuals in the Insured's state of residence. We will give the Insured 31 days written notice before any premium change.

THIS IS A LIMITED POLICY.

READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE.

TABLE OF CONTENTS

INSURED SCHEDULE

		Renewal Premium:	Direct Bill	Bank Draft
Policy Number	00-00-000000	Monthly	N/A	$00.00
Effective Date	Jan. 1, 2009	Quarterly	$00.00	$00.00
Initial Term Expires	Jan. 1, 2009	Semi Annual	$00.00	N/A
Initial Premium	$00.00	Annual	$00.00	N/A
Insured	**JOHN DOE**	Agent	RESERVE NATIONAL AGENT	

Dependents

Spouse **JANE DOE**

DEPENDENT 2
DEPENDENT 3
DEPENDENT 4
DEPENDENT 5
DEPENDENT 6
DEPENDENT 7

Benefits and Limitations

Hospital Confinement Benefit:
- Elimination Period (must be satisfied each Policy Year) ……2 Days
- For the First 10 Full Days of Hospital Confinement after Elimination Period ……$1,000.00 Per Day
- For the Next 21 Full Days of Hospital Confinement ..... …$500.00 Per Day
- Maximum Hospital Confinement Benefit Period..... 31 Days of Confinement Per Policy Year (Unused days are not carried forward)

Inpatient Doctor Visits Benefit .....$75.00 Per Visit, Limited to 10 Visits Per Policy Year

Outpatient Doctor Visits Benefit .....$65.00 Per Visit, Limited to 2 Visits Per Policy Year

Prescriptions, X-Rays and Lab Tests Benefit:
- Benefit Per Prescription, X-Ray or Lab Test……$50.00
- Maximum Benefit Per Policy Year……$250.00

Home Health Care Benefit:
- Daily Maximum Aggregate Benefit.....$150.00
- Maximum Benefit Period ..... 100 Days

Home Health Care Aide Benefit:
- Daily Benefit $40.00
- Maximum Benefit Period .....60 Days

Optional Surgical Benefit Rider:
- Surgeon's Benefit ..... See Schedule of Surgical Operations
- Anesthesia Benefit..... 25% of the Applicable Surgeon's Benefit
- Outpatient Surgical Facility Benefit $500.00

- Endorsements, if any, on reverse side -

Endorsements

DEFINITIONS

The following terms in this Policy are defined as follows:

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid. Upon the insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death.

PHYSICIAN: "Physician" means any legally qualified individual (other than you, your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence) who is duly licensed and practicing the healing arts within the scope of his/her authority and license.

INJURY: "Injury" means a Covered Person's accidental bodily injury resulting directly and independently of all other causes from an accident which occurs while a Covered Person whose injury is the basis of a claim is covered under this Policy, and which causes loss while this Policy is in force.

SICKNESS: "Sickness" means a Covered Person's sickness or disease that manifests itself after this Policy's Effective Date, and causes loss while this Policy is in force. The term "Sickness" shall be deemed to include all Sicknesses or diseases suffered concurrently.

ELIMINATION PERIOD: "Elimination Period" means the number of consecutive full days of confinement in a Hospital, beginning with the first day of Hospital confinement, before the Hospital Confinement Benefit is payable. A Covered Person must satisfy the Elimination Period in each Policy Year before the Hospital Confinement Benefit is payable to that Covered Person in that Policy Year. A "day" is a 24-hour period.

HOSPITAL: "Hospital" means only a legally constituted institution which operates pursuant to law and is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a prearranged contractual basis) facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, for which a charge is made, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing service by or under the supervision of registered nurses on duty. "Hospital" does not mean convalescent, nursing, rest, or extended care facilities, or facilities operated exclusively for treatment of the aged, or drug or alcohol abuse, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the 12-month period immediately preceding the Effective Date of this Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the 12-month period following the Effective Date of this Policy.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy, so that each successive 12-month period constitutes a single Policy Year.

BENEFITS

HOSPITAL CONFINEMENT BENEFIT

(a) If a Covered Person, while this Policy is in force, is confined in a Hospital as a resident inpatient as a result of an Injury or Sickness, we will pay, beginning with the first day of such Hospital confinement following the Elimination Period, the Hospital Confinement Benefit in the amount shown on the Insured Schedule for each day of such confinement. This benefit is subject to the Maximum Hospital Confinement Benefit Period shown on the Insured Schedule for each Policy Year.

(b) A "day" is a 24-hour period. No benefit is payable for a partial day of Hospital confinement.

(c) The Hospital confinement must be upon the recommendation of a Physician.

(d) The maximum number of days the Benefit for Hospital Confinement will be payable in any Policy Year is the Maximum Hospital Confinement Benefit Period shown on the Insured Schedule. Unused days in one Policy Year are not carried forward to any future Policy Year.

BENEFITS (Continued)

INPATIENT DOCTOR VISITS BENEFIT

If a Covered Person, while this Policy is in force, is confined in a Hospital as a resident inpatient as a result of an Injury or Sickness, we will pay the Inpatient Doctor Visits Benefit in the amount shown on the Insured Schedule for each day such Covered Person receives personal treatment by a Physician, limited to 10 visits in a Policy Year. This benefit is payable only for a day on which (a) a Covered Person is confined in a Hospital as a result of an Injury or Sickness and (b) the Covered Person receives personal treatment by a Physician. Each Covered Person is limited to one Benefit for Inpatient Doctor Visits for each day he/she receives personal treatment by one or more Physicians while confined in a Hospital.

OUTPATIENT DOCTOR VISITS BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit per day, and not to exceed two visits in a Policy Year.

PRESCRIPTIONS, X-RAYS AND LAB TESTS BENEFIT

If a Covered Person, while this Policy is in force, purchases a Prescription Drug, or undergoes an X-Ray or a laboratory test as the result of an Injury or Sickness, we will pay $50.00 for each such Prescription Drug, X-Ray or laboratory test, limited to a maximum aggregate benefit of $250.00 for all Prescription Drugs, X-Rays and laboratory tests per Policy Year. For purposes of this benefit, "Prescription Drug" means a drug or medication which: (a) requires a prescription written by a Physician and (b) is dispensed by a licensed pharmacist.

HOME HEALTH CARE BENEFIT

If a Covered Person, while this Policy is in force, requires Home Health Care provided by an Approved Home Health Care Practitioner as a result of any one Injury or Sickness, subject to the eligibility conditions below, we will pay a daily benefit for each day such care is provided. The amount of the daily benefit for all Home Health Care services for any one day will be the lesser of: (a) the Daily Maximum Aggregate Benefit shown on the Insured Schedule or (b) the amount set forth opposite the Home Health Care Services listed below:

Home Health Care Services	Daily Benefit
Skilled Nursing Care (provided by a licensed registered nurse [R.N.])	$75.00
General Nursing Care (provided by a licensed practical nurse [L.P.N.], licensed vocational nurse [L.V.N.] or licensed visiting nurse)	$60.00
Physical Therapy	$75.00
Speech Pathology	$75.00
Occupational Therapy	$75.00
Chemotherapy Specialist Services	$60.00
Enterostomal Therapy	$50.00
Respiration Therapy	$50.00
Medical Social Services	$100.00

The number of days the Home Health Care Benefit is payable will not exceed the Maximum Benefit Period shown on the Insured Schedule.

BENEFITS (Continued)

HOME HEALTH CARE AIDE BENEFIT

If a Covered Person, while this Policy is in force, immediately following a Hospital confinement of not less than three days, requires the services of a Home Health Care Aide, subject to the eligibility conditions below, we will pay a daily benefit in the amount shown on the Insured Schedule for each day such services are provided in Your Home. The number of days the Home Health Care Aide Benefit is payable will not exceed the Maximum Benefit Period shown on the Insured Schedule.

CONDITIONS ON ELIGIBILITY FOR THE HOME HEALTH CARE BENEFIT AND THE HOME HEALTH CARE AIDE BENEFIT

Payment of the Home Health Care Benefit and the Home Health Care Aide Benefit is subject to the following:

(a) The Covered Person's loss must be incurred after this Policy's Effective Date and while the Policy is in force;

(b) For the Home Health Care Benefit, care must be provided in Your Home by an Approved Home Health Care Practitioner, as defined herein; and for the Home Health Care Aide Benefit, care must be provided in Your Home by a Home Health Care Aide, as defined herein; and

(c) The Covered Person must be unable to perform, without the assistance of another person, two or more Activities of Daily Living; or the Covered Person must require continuous supervision and assistance due to a Cognitive Impairment. To meet this condition (c), the Covered Person's Physician must perform tests in accordance with accepted standards of medical practice and, based on such tests, certify in writing that the Covered Person is unable to perform two or more Activities of Daily Living or that the Covered Person has a Cognitive Impairment.

MAXIMUM BENEFIT PERIODS

(a) The Maximum Benefit Period for the Home Health Care Benefit is set forth on the Insured Schedule. This is the maximum number of days we will pay the Home Health Care Benefit during a Covered Person's lifetime, unless benefits are restored as provided in the Restoration of Benefits provision. The Maximum Benefit Period is calculated in continuous days from the first day for which the Home Health Care Benefit is payable, and each day you receive any services from an Approved Home Health Care Practitioner will count as one full day toward the maximum, without regard to whether or not the Covered Person's Home Health Care is continuous.

(b) The Maximum Benefit Period for the Home Health Care Aide Benefit is set forth on the Insured Schedule. This is the maximum number of days we will pay the Home Health Care Aide Benefit during a Covered Person's lifetime, unless benefits are restored as provided in the Restoration of Benefits provision. The Maximum Benefit Period is calculated in continuous days from the first day for which the Home Health Care Aide Benefit is payable, and each day you receive any services from a Home Health Care Aide will count as one full day toward the maximum, without regard to whether or not such services are continuous.

RESTORATION OF BENEFITS

If a Covered Person has received the Home Health Care Benefit under this Policy and has used up all or a portion of the Maximum Benefit Period, but has recovered sufficiently to no longer require Home Health Care, we will restore that Covered Person's Maximum Benefit Period to its full original maximum each time the following conditions are met: (a) the Covered Person must not have received the services of an Approved Home Health Care Practitioner or a Home Health Care Aide for a period of 180 consecutive days; and (b) the Covered Person's Physician must certify that the Covered Person has sufficiently recovered to no longer require any services of an Approved Home Health Care Practitioner or a Home Health Care Aide and that the Covered Person was not advised to obtain such services. There is no limit to the number of times the Covered Person's Maximum Benefit Period for the Home Health Care Benefit may be restored. If the Maximum Benefit Period for the Home Health Care Benefit is restored, the Maximum Benefit Period for the Home Health Care Aide Benefit will also be restored.

DEFINITIONS FOR THE HOME HEALTH CARE BENEFIT AND THE HOME HEALTH CARE AIDE BENEFIT

As related to the Home Health Care Benefit and the Home Health Care Aide Benefit, the following terms are defined as follows:

ACTIVITIES OF DAILY LIVING: "Activities of Daily Living" means bathing (getting in and out of the bath tub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps); dressing (tying shoes, buttoning buttons or clasps); eating (consuming food or drink, or utilizing utensils, appropriate for the person's physical condition and which are placed within reach); toileting (maintaining adequate bathroom hygiene and toilet habits); and transferring to or from bed or chair (getting from a bed to a chair or a chair to a bed).

APPROVED HOME HEALTH CARE PRACTITIONER: "Approved Home Health Care Practitioner" means a licensed registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), licensed visiting nurse, physical therapist, speech pathologist, occupational therapist, chemotherapy specialist, enterostomal therapist, respiratory therapist or medical social worker. All such practitioners must be licensed or certified by the appropriate regulatory authority and may not be a member of a Covered Person's Immediate Family.

COGNITIVE IMPAIRMENT: "Cognitive Impairment" means a deficiency in the ability to think, perceive, reason and/or remember, which results in the inability to take care of oneself without the ongoing assistance of another person. Cognitive Impairment is evaluated and measured through clinical evidence and standardized tests. Cognitive Impairment is indicated by measurable deficits in memory, orientation or reasoning, such as those caused by Alzheimer's Disease or similar forms of senility or irreversible dementia.

HOME HEALTH CARE: "Home Health Care" means professional nursing and therapy services which are provided by an Approved Home Health Care Practitioner in Your Home. Home Health Care does not include services provided by a Home Health Care Aide.

HOME HEALTH CARE AIDE: "Home Health Care Aide" means any individual, other than a member of a Covered Person's Immediate Family, working under the supervision of a licensed graduate nurse who is qualified, by training and experience, to provide assistance with Activities of Daily Living and has been certified as a Home Health Care Aide by the appropriate regulatory authority.

IMMEDIATE FAMILY: "Immediate Family" means a Covered Person, his or her spouse and their respective parents, children, grandchildren and siblings.

YOUR HOME: "Your Home" means the place where a Covered Person maintains independent residence. It does not mean a nursing facility, hospital or other institutional setting.

EXCLUSIONS

This Policy does not cover any loss caused or contributed to by: (a) Injury or Sickness sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by this Policy while you are in such service); (b) suicide or attempted suicide, while sane or insane, or any intentionally self-inflicted Injury; (c) drug abuse, drug overdose or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) Injury or Sickness covered by any worker's compensation act, occupational diseases law or any motor vehicle no-fault law; (g) dental care or treatment, **except** that excluded dental care or treatment shall not include (1) reconstructive surgery when such service is incidental to trauma or (2) treatment of accidental injury to whole natural teeth received within six months following an accident; (h) cosmetic or elective surgery (including surgery to correct myopia, hyperopia, presbyopia or astigmatism and surgery for weight loss or modification), **except** that excluded cosmetic surgery shall not include (1) reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, (2) reconstructive surgery because of congenital disease or anomaly of an insured dependent child which has resulted in a functional defect or (3) breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed; (i) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (j) childbirth; (k) participation in a felony or attempted felony, riot or insurrection; (l) rest cures, custodial care and routine physical examinations; (m) surgical sterilization; (n) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (o) eye glasses, hearing aids and examination for the prescription or fitting thereof.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions are not covered under this Policy until this Policy has been in force for a period of 12 months; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under this Policy by name or specific description on the date of the loss.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to the Company at its Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as provided in the Grace Period provision.

(b) Premiums are subject to change. Premiums for this Policy are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status and the Insured's state of residence. Any change will apply to future premiums for all policies with the same form number issued by us to individuals in the Insured's state of residence. We will give the Insured 31 days written notice before any premium change. No change in premium will be effective before the first policy anniversary.

TERMINATION

Subject to the Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Coverage for Spouse and Dependent Children provision.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are unmarried and under 19 years of age and who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN (Continued)

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

The coverage on any child will terminate on the anniversary date of this Policy after the child's 19th birthday, or the child's marriage, whichever occurs first. Termination of coverage shall be without prejudice to any claim originating prior thereto. Our acceptance of premium after such date shall be for the remaining persons who qualify for coverage under this Policy; provided that coverage shall continue for any Covered Person during the period for which we accept an identifiable premium for such Covered Person. Coverage may be continued for any covered dependent child regardless of age who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 19. Proof of such incapacity and dependency must be furnished to us by you at our request and expense.

If the coverage of a child terminates under this provision due to his/her attaining age 19 or marriage, such child shall be eligible to have issued to him/her without evidence of insurability a policy with benefit and renewability provisions the same as or similar to this Policy that the Company is then issuing.

RENEWAL SAFEGUARD

This Policy is renewable as follows:

(a) The Company may not decline to renew this Policy except for one or both of the following reasons:

(1) Renewal premiums are declined on all policies bearing the same form number as this Policy issued to persons in the same state in which the Insured resides; or

(2) Failure to correctly report matters inquired of in the application for this Policy.

(b) While this Policy is in effect, the Company shall not have the right to place any restrictive amendment hereon with respect to any coverage in effect hereunder. **There shall be no change in rate classification on account of any physical impairment of a Covered Person or on account of any claims incurred under this Policy.**

(c) The Company's right to refuse renewal, which is expressly reserved as set forth in (a) above, may be exercised by giving written notice, at least thirty (30) days prior to the expiration of the term for which premium has been paid, to the Insured by either delivery or by mailing to his last address as shown by the records of the Company when, not less than thirty (30) days thereafter, such refusal of renewal shall be effective.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy with any endorsements or attachments, is the entire contract of insurance. Only one of our executive officers can approve a change. Such approval must be endorsed on or attached to this Policy. It may not be changed in any way by any agent.

UNIFORM PROVISIONS (Continued)

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After two years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person eligible for coverage under this Policy, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for loss incurred commencing after expiration of such two years.

(b) No claim for loss incurred that starts after 12 months from the Effective Date of coverage will be reduced or denied because a Sickness or condition had existed before the Effective Date of coverage. This does not include diseases or physical conditions excluded specifically by name or description on an elimination endorsement or in the Exclusions provision.

3. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, the Policy shall continue in force.

4. REINSTATEMENT: This Policy shall lapse if you do not pay the premium before the end of the grace period. If we or any agent authorized by us to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. If we do not approve it, this Policy shall be reinstated on the 45th day after such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only an Injury caused by an accident occurring after the date of reinstatement or a Sickness beginning more than 10 days from such date. In all other respects you and the Company shall have the same rights under this Policy as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and Policy number. Notice should be mailed to us at our home office at 6100 N.W. Grand Blvd., Oklahoma City, Oklahoma 73118-1082, or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will give or provide you forms for filing proof of loss. If we do not give or provide them within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. This statement should include the type and extent of the loss you incurred. We must receive this statement within the time given for filing proof of loss.

7. PROOF OF LOSS: If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. TIME OF PAYMENT OF CLAIMS: We will pay benefits immediately upon receipt of due written proof of loss for benefits provided under this Policy. However, a benefit that is payable by periodic payments, subject to due written proof of loss, shall be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

9. PAYMENT OF CLAIM: (a) Subject to the Direct Payment of Hospital, Medical Services provision, benefits will be paid to you. Loss-of-life benefits, if any, are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. (b) If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000 to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

10. PHYSICAL EXAMINATION: We, at our expense, may have you examined when and as often as we may reasonably require while a claim is pending.

UNIFORM PROVISIONS (Continued)

11. LEGAL ACTIONS: No legal action may be brought to recover on this Policy within 60 days after written proof of such loss has been given as required by the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be given.

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this Policy. Also, no such consent shall be required for surrender or assignment of this Policy.

13. CANCELLATION: This Policy may not be cancelled by the Company, nor by you, during a period for which premium has been paid and officially accepted by the Company. The Company may not decline to renew this Policy, except as provided in the Termination provision or the Renewal Safeguard provision.

POLICY PROVISIONS

1. MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated, all benefits payable to that person shall be in the amount the premiums paid would have purchased at the correct age.

2. UNPAID PREMIUM: Any due and unpaid premium for this Policy may be deducted from its benefits then payable.

3. ILLEGAL OCCUPATION: We shall not be liable for any loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for any loss to which a contributing cause was your participation in an illegal occupation or illegal activity.

4. INTOXICANTS AND NARCOTICS: We shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

5. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.

6. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES: Subject to any written direction of the Insured, all or any portion of any indemnities provided hereunder on account of hospital, nursing, medical or surgical services may, at the Company's option, and unless the Insured requests otherwise, not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services.

7. ALTERNATIVE DISPUTE RESOLUTION: If a dispute arises between a Covered Person and the Company concerning the payment or non-payment of benefits under this Policy, either party may request that the dispute be referred to mediation. Such a request must be submitted to the other party in writing and must include a description of the issue(s) in dispute. The parties will then contact the American Arbitration Association, which will appoint a mediator who is experienced in resolving health insurance disputes.

If the decision of the mediator is in favor of the Covered Person, the Company will accept the decision and pay the cost of the mediator and any experts he/she consults with.

If the decision of the mediator is in favor of the Company, the Company will pay the cost of the mediator and any experts he/she consults with.

This provision will not affect any right of a Covered Person under the Legal Actions provision of this Policy or applicable law.

8. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON: In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.

POLICY PROVISIONS (Continued)

9. CONTINUATION OF COVERAGE UPON DIVORCE: If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under the Policy.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the effective date, and to be executed by its President and Secretary at its Home Office at 6100 Northwest Grand Boulevard, in the City of Oklahoma City, Oklahoma.

Secretary

President

IMPORTANT NOTICE

Customer Service Department of Reserve National Insurance Company:
6100 Northwest Grand Boulevard
Oklahoma City, Oklahoma 73118-1082
Telephone # 1-800-654-9106.

If we at Reserve National Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone (501) 371-2600

SURGICAL BENEFIT RIDER

In consideration of the additional premium and effective with the date of issue, coverage under the Policy to which this Rider is attached is extended to add the following benefits:

SURGEON'S BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness, we will pay the applicable amount shown on the Schedule of Surgical Operations. The maximum aggregate benefit payable under this provision for all surgical operations shall be limited to $2,000.00 in any Policy Year. This benefit is payable for surgery performed either on an inpatient or outpatient basis.

ANESTHESIA BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness, and is administered anesthesia during such surgical operation, we will pay 25% of the benefit payable under the Surgeon's Benefit.

OUTPATIENT SURGICAL FACILITY BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness for which Surgical Benefits under this Policy are payable, and the surgical operation is performed on an outpatient basis in a Hospital, ambulatory surgical center, licensed clinic, Physician's office or any other facility appropriately licensed for the performance of outpatient surgery, we will pay the Outpatient Surgical Facility Benefit in the amount shown on the Insured Schedule.

All the provisions, conditions, limitations and exclusions of the Policy to which this Rider is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this Rider.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Rider to be executed by its President and attested by its Secretary.

Secretary

President

SCHEDULE OF OPERATIONS FOR SURGEON'S BENEFIT

HEAD
Burr Holes hematoma ..... $ 980.00
Craniectomy hematoma 1190.00
Craniotomy skull tumor 2000.00
Intracranial aneurysm 1610.00

EAR
Mastoidectomy - radical 1500.00
Mastoidectomy - simple 700.00
Myringotomy 150.00
Stapedectomy 910.00
Tympanoplasty 910.00
Tympanotomy 150.00

EYE
Blepharoptosis 500.00
Cataract removal Surgical or Laser 700.00
Cataract removal with lens implant 800.00
Detached retina repair 700.00
Enucleation of eyeball 400.00
Iridectomy 600.00
Keratotomy 600.00
Lens implant 600.00
Pterygium excision 300.00
Sclerotomy 600.00
Strabismus repair 500.00
Vitrectomy 600.00

NOSE
Antrum puncture for drainage 100.00
Ethmoidectomy 450.00
Polypectomy 200.00
Rhinoplasty 800.00
Septoplasty 600.00
Submucous resection 450.00

THROAT . NECK
Laryngoscopy 250.00
Radical neck dissection for tumor 2000.00
Removal of larynx 1400.00
Removal of tumor larynx 700.00
Removal vocal cord 800.00
Thyroidectomy 1000.00
Tonsillectomy adnoidectomy 300.00

CHEST
Bronchoscopy 400.00
Esophagoscopy 150.00
Esophagogastroduodenoscopy 300.00
Lobectomy 1200.00
Mediastinoscopy 400.00
Mediastinotomy 200.00
Pleura Needle Biopsy 150.00
Pneumonectomy 1400.00
Thoracentesis 100.00
Thoracoplasty 1400.00

BREAST
Breast aspiration 100.00
Breast biopsy 160.00
Radical mastectomy
Bilateral 1500.00
Unilateral 800.00
Removal of tumor or cyst 300.00
Simple mastectomy
Bilateral 600.00
Unilateral 500.00

CARDIOVASCULAR
Aortic valve replacement 2000.00
Combined left and right heart catheterization 600.00
Coronary angioplasty 1750.00
Coronary artery bypass 2000.00
Embolectomy 600.00
Endarterectomy 1750.00
Left heart catheterization, coronary angiography 600.00
Mitral valve replacement 2000.00
Pericardiectomy 1200.00
Pericardiotomy 800.00
Permanent pacemaker insertion 800.00
Popliteal artery bypass 1120.00
Repair of aneurysm 1750.00
Right heart catheterization, Swan-Ganz 550.00
Thrombectomy 600.00
Varicose vein stripping 400.00

ABDOMEN
Appendectomy 700.00
Biopsy of liver 450.00
Biopsy of pancreas 500.00
Cholecystectomy 700.00
Colostomy 800.00
Diverticulectomy 600.00
Enterolysis 650.00
Exploratory laparotomy 700.00
Gastrectomy
Sub Total 1200.00
Total 1500.00
Gastro-enterostomy 1000.00
Hernia,
inguinal bilateral 800.00
inguinal unilateral 500.00
Hernia,
umbilical 500.00
Hernia
ventral 600.00
Intestinal – resection 800.00
Omentectomy 600.00
Splenectomy 800.00
Vagotomy & Pyloroplasty 800.00

SCHEDULE OF OPERATIONS FOR SURGEON'S BENEFIT
(Continued)

GENITO-URINARY TRACT

Adrenalectomy	900.00
Cystectomy	800.00
Cystolithotomy	850.00
Cystoscopy	250.00
Epididymectomy	450.00
Hydrocele	500.00
Lithotripsy	800.00
Marshall Marchetti Krantz	900.00
Nephrectomy	1400.00
Nephrolithotomy	850.00
Orchiectomy	500.00
Suprapubic prostatectomy	900.00
TUR - prostate	900.00
Ureterolithotomy	1200.00
Urethral dilation	100.00
Varicocele	600.00

GYNECOLOGY

Bartholin gland incision	200.00
Biopsy of cervix	200.00
Biopsy of endometrium	200.00
Cautery of cervix	200.00
Cystocele/Rectocele	600.00
Dilatation and curettage	350.00
Hysterectomy, abdominal	1000.00
Hysterectomy, vaginal	900.00
Hysterosalpingography	200.00
Laparoscopy	400.00
Oophorectomy	600.00
Salpingectomy	800.00
Uterine suspension	500.00
Vaginal fistula	450.00

RECTUM

Colonoscopy fiberoptic	300.00
with biopsy	400.00
with removal of polyp	500.00
Fistulectomy	500.00
Fissure-ano	300.00
Hemorrhoidectomy	600.00
I&D abscess	100.00
Pilonidal	300.00
Proctectomy	1400.00
Proctopenneoplasty	600.00
Proctoscopy	150.00
Sigmoidoscopy	300.00

FRACTURES

Carpal-Metacarpal	250.00
Clavicle	200.00
Femur	600.00
Fibula	500.00
Finger-Tarsal-Metatarsal	200.00
Humerus	500.00
Mandible	600.00
Maxilla, skull, simple	800.00

FRACTURES (continued)

Nose	400.00
Patella	300.00
Pelvis	400.00
Radius	400.00
Ribs	100.00
Scapula	150.00
Spine	500.00
Tibia	550.00
Ulna	350.00

Amounts above are for simple fracture. For open reduction maximum will be one and one-half times the amount for simple fracture. For open fracture requiring metallic fixation the amount will be twice the amount for simple fracture.

AMPUTATIONS

Above elbow	600.00
Above knee	1000.00
Below elbow	600.00
Below knee	800.00
Finger or Toe	250.00
Transmetatarsal	500.00

SPINE

Diskectomy	1100.00
Laminectomy	1260.00
Myelogram	300.00

ORTHOPEDIC

Arthroplasty, hip	1200.00
Arthroplasty, knee	800.00
Arthroscopy, knee	400.00
Arthrotomy, knee with meniscectomy	800.00
Bunionectomy	400.00
Excision Morton's neuroma	300.00
Hammertoe repair	400.00
Neurolysis median nerve at Carpal tunnel	400.00
Repair rotator cuff	650.00

MISCELLANEOUS

Removal of tumors, cysts or abscess	
benign - face, nose, ears	200.00
benign - scalp, neck, hand, foot	150.00
benign - trunk, arm, leg	100.00
malignant - face, nose, ears	250.00
malignant - scalp, neck, hand, foot	200.00
malignant - trunk, arm, leg	150.00
Suturing of surface wounds	
face and mucous membrane	150.00
scalp, neck, genitalia, trunk extremities	100.00

For surgical operations not otherwise specified, the Company will determine the amount to be included as a covered charge on a basis commensurate to similar listed operations, but in no event shall the maximum covered charge for operations not specified exceed Two Thousand ($2,000.00) Dollars.

SURGICAL BENEFIT RIDER

In consideration of the additional premium and effective with the date of issue, coverage under the Policy to which this Rider is attached is extended to add the following benefits:

SURGEON'S BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness, we will pay the applicable amount shown on the Schedule of Surgical Operations. The maximum aggregate benefit payable under this provision for all surgical operations shall be limited to $3,000.00 in any Policy Year. This benefit is payable for surgery performed either on an inpatient or outpatient basis.

ANESTHESIA BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness, and is administered anesthesia during such surgical operation, we will pay 25% of the benefit payable under the Surgeon's Benefit.

OUTPATIENT SURGICAL FACILITY BENEFIT

If a Covered Person, while this Policy is in force, has a surgical operation performed by a Physician as a result of an Injury or Sickness for which Surgical Benefits under this Policy are payable, and the surgical operation is performed on an outpatient basis in a Hospital, ambulatory surgical center, licensed clinic, Physician's office or any other facility appropriately licensed for the performance of outpatient surgery, we will pay the Outpatient Surgical Facility Benefit in the amount shown on the Insured Schedule.

All the provisions, conditions, limitations and exclusions of the Policy to which this Rider is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this Rider.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Rider to be executed by its President and attested by its Secretary.

Secretary

President

SCHEDULE OF OPERATIONS FOR SURGEON'S BENEFIT

HEAD

Burr Holes hematoma	$ 1470.00
Craniectomy hematoma	1785.00
Craniotomy skull tumor	3000.00
intracranial aneurysm	2415.00

EAR

Mastoidectomy - radical	2250.00
Mastoidectomy - simple	1050.00
Myringotomy	225.00
Stapedectomy	1365.00
Tympanoplasty	1365.00
Tympanotomy	225.00

EYE

Blepharoptosis	750.00
Cataract removal Surgical or Laser	1050.00
Cataract removal with lens implant	1200.00
Detached retina repair	1050.00
Enucleation of eyeball	600.00
Iridectomy	900.00
Keratotomy	900.00
Lens implant	900.00
Pterygium excision	600.00
Sclerotomy	900.00
Strabismus repair	750.00
Vitrectomy	900.00

NOSE

Antrum puncture for drainage	150.00
Ethmoidectomy	675.00
Polypectomy	300.00
Rhinoplasty	1200.00
Septoplasty	900.00
Submucous resection	675.00

THROAT - NECK

Laryngoscopy	375.00
Radical neck dissection for tumor	3000.00
Removal of larynx	2100.00
Removal of tumor larynx	1050.00
Removal vocal cord	1200.00
Thyroidectomy	1500.00
Tonsillectomy adnoidectomy	450.00

CHEST

Bronchoscopy	600.00
Esophagoscopy	225.00
Esophagogastroduodenoscopy	450.00
Lobectomy	1800.00
Mediastinoscopy	600.00
Mediastinotomy	300.00
Pleura Needle Biopsy	225.00
Pneumonectomy	2100.00
Thoracentesis	150.00
Thoracoplasty	2100.00

BREAST

Breast aspiration	150.00
Breast biopsy	240.00
Radical mastectomy	
Bilateral	2250.00
Unilateral	1200.00
Removal of tumor or cyst	450.00
Simple mastectomy	
Bilateral	900.00
Urillatoral	750.00

CARDIOVASCULAR

Aortic valve replacement	3000.00
Combined left and right heart catheterization	900.00
Coronary angioplasty	2625.00
Coronary artery bypass	3000.00
Embolectomy	900.00
Endarterectcimny	2625.00
Left heart catheterization, coronary angiotjraphy	900.00
Mitral valve replacement	3000.00
Pericardiectomy	1800.00
Pericardiotomy	1200.00
Permanent pacemaker insertion	1200.00
Popliteal artery bypass	1680.00
Repair of aneurysm	2625.00
Right heart catheterization, Swan-Ganz	825.00
Thrombectomy	900.00
Varicose vein stripping	600.00

ABDOMEN

Appendectomy	1050.00
Biopsy of liver	675.00
Biopsy of pancreas	750.00
Cholecystectomy	1050.00
Colostomy	1200.00
Diverticulectomy	900.00
Enterolysis	975.00
Exploratory laparotomy	1050.00
Gastrectomy	
Sub Total	1800.00
Total	2250.00
Gastro-enterostomy	1500.00
Hernia,	
inguinal bilateral	1200.00
inguinal unilateral	750.00
Hemia,	
umbilical	750.00
Hernia	
ventral	900.00
Intestinal resection	1200.00
Omentectomy	900.00
Splenectomy	1200.00
Vagotomy & Pyloroplasty	1200.00

SCHEDULE OF OPERATIONS FOR SURGEON'S BENEFIT
(Continued)

GENITO-URINARY TRACT

Adrenalectomy	1350.00
Cystectomy	1200.00
Cystolithotomy	1275.00
Cystoscopy	375.00
Epididymectomy	675.00
Hydrocele	750.00
Lithotripsy	1200.00
Marshall Marchetti Krantz	1350.00
Nephrectomy	2100.00
Nephrolithotomy	1275.00
Orchiectomy	750.00
Suprapubic prostatectomy	1350.00
TUR - prostate	1350.00
Ureterolithotomy	1800.00
Urethral dilation	150.00
Varicocele	900.00

GYNECOLOGY

Bartholin gland incision	300.00
Biopsy of cervix	300.00
Biopsy of endometrium	300.00
Cautery of cervix	300.00
Cystocele/Rectocele	900.00
Dilatation and curettage	525.00
Hysterectomy, abdominal	1500.00
Hysterectomy, vaginal	1350.00
Hysterosalpingography	300.00
Laparoscopy	600.00
Oophorectomy	900.00
Salpingectomy	1200.00
Uterine suspension	750.00
Vaginal fistula	675.00

RECTUM

Colonoscopy fiberoptic	450.00
with biopsy	600.00
with removal of polyp	750.00
Fistulectomy	750.00
Fissure-ano	450.00
Hemorrhoidectomy	900.00
I&D abscess	150.00
Pilonidal	450.00
Proctectomy	2100.00
Proctoperineoplasty	900.00
Proctoscopy	225.00
Sigmoidoscopy	450.00

FRACTURES

Carpal-Metacarpal	375.00
Clavicle	300.00
Femur	900.00
Fibula	750.00
Finger-Tarsal-Metatarsal	300.00
Humerus	750.00
Mandible	900.00
Maxilla, skull, simple	1200.00

FRACTURES (continued)

Nose	600.00
Patella	450.00
Pelvis	600.00
Radius	600.00
Ribs	150.00
Scapula	225.00
Spine	750.00
Tibia	825.00
Ulna	525.00

Amounts above are for simple fracture. For open reduction maximum will be one and one-half times the amount for simple fracture. For open fracture requiring metallic fixation the amount will be twice the amount for simple fracture.

AMPUTATIONS

Above elbow	900.00
Above knee	1500.00
Below elbow	900.00
Below knee	1200.00
Finger or Toe	375.00
Transmetatarsal	750.00

SPINE

Diskectomy	1650.00
Laminectomy	1890.00
Myelogram	450.00

ORTHOPEDIC

Arthroplasty, hip	1800.00
Arthroplasty, knee	1200.00
Arthroscopy, knee	600.00
Arthrotomy, knee with meniscectomy	1200.00
Bunionectomy	600.00
Excision Morton's neuroma	450.00
Hammertoe repair	600.00
Neurolysis median nerve at Carpal tunnel	600.00
Repair rotator cuff	975.00

MISCELLANEOUS

Removal of tumors, cysts or abscess	
benign - face, nose, ears	300.00
benign - scalp, neck, hand, foot	225.00
benign - trunk, arm, leg	150.00
malignant - face, nose, ears	375.00
malignant - scalp, neck, hand, foot	300.00
malignant - trunk, arm, leg	225.00
Suturing of surface wounds	
face and mucous membrane	225.00
scalp, neck, genitalia, trunk extremities	150.00

For surgical operations not otherwise specified, the Company will determine the amount to be included as a covered charge on a basis commensurate to similar listed operations, but in no event shall the maximum covered charge for operations not specified exceed Three Thousand ($3,000.00) Dollars.

ENDORSEMENT AND PHOTOSTAT OF APPLICATION ATTACHED HERETO CONSTITUTE PART OF THE CONTRACT

6100 NORTHWEST GRAND BLVD.
OKLAHOMA CITY, OKLAHOMA 73118-1082

FIXED INDEMNITY POLICY

This Policy provides a fixed indemnity benefit for covered treatment of a Covered Person's Injury or Sickness.
Read it carefully with the outline of coverage.

SIP-1

Reserve National
INSURANCE COMPANY
5100 NORTHWEST GRAND BLVD. - OKLAHOMA CITY, OKLAHOMA 73118-1082

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or other information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For you own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might been payable under you present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of you present policy. This is not your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____
Date

_____
Applicant’s Signature

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SIP-1 Fixed Indemnity Policy*		
Project Name/Number:	*SIP-1 Fixed Indemnity Policy/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SIP-1 Fixed Indemnity Policy*		
Project Name/Number:	*SIP-1 Fixed Indemnity Policy/*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved-Closed	Rates	SIP-1	New		Rates SIP-1.pdf

Exhibit II

Special Indemnity Policy Form SIP-1

Regular Monthly Premium Rates / Nontobacco

No Elimination Period			One Day Elimination Period			Two Day Elimination Period			Three Day Elimination Period			Surgery Rider		
Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$2,000	$3,000
0-17	85	125	0-17	75	106	0-17	68	92	0-17	63	82	0-17	58	76
18	118	188	18	101	155	18	89	130	18	80	113	18	70	90
19	118	188	19	101	155	19	89	130	19	80	113	19	70	90
20	118	188	20	101	155	20	89	130	20	80	113	20	70	90
21	118	188	21	101	155	21	89	130	21	80	113	21	70	90
22	118	188	22	101	155	22	89	130	22	80	113	22	70	90
23	123	198	23	105	162	23	92	136	23	83	118	23	77	99
24	123	198	24	105	162	24	92	136	24	83	118	24	77	99
25	123	198	25	105	162	25	92	136	25	83	118	25	77	99
26	126	204	26	107	167	26	94	139	26	84	121	26	86	112
27	126	204	27	107	167	27	94	139	27	84	121	27	86	112
28	126	204	28	107	167	28	94	139	28	84	121	28	86	112
29	131	213	29	111	174	29	97	145	29	87	125	29	90	117
30	131	213	30	111	174	30	97	145	30	87	125	30	90	117
31	131	213	31	111	174	31	97	145	31	87	125	31	90	117
32	136	223	32	115	181	32	100	151	32	89	130	32	93	122
33	136	223	33	115	181	33	100	151	33	89	130	33	93	122
34	136	223	34	115	181	34	100	151	34	89	130	34	93	122
35	139	229	35	117	186	35	102	154	35	91	133	35	97	126
36	139	229	36	117	186	36	102	154	36	91	133	36	97	126
37	139	229	37	117	186	37	102	154	37	91	133	37	97	126
38	144	238	38	121	193	38	105	160	38	93	137	38	101	132
39	144	238	39	121	193	39	105	160	39	93	137	39	101	132
40	144	238	40	121	193	40	105	160	40	93	137	40	101	132
41	149	248	41	125	200	41	108	166	41	96	142	41	105	137
42	149	248	42	125	200	42	108	166	42	96	142	42	105	137
43	149	248	43	125	200	43	108	166	43	96	142	43	105	137
44	157	263	44	131	212	44	113	175	44	100	149	44	112	146
45	157	263	45	131	212	45	113	175	45	100	149	45	112	146
46	157	263	46	131	212	46	113	175	46	100	149	46	112	146
47	164	277	47	137	223	47	118	184	47	104	156	47	120	158
48	164	277	48	137	223	48	118	184	48	104	156	48	120	158
49	164	277	49	137	223	49	118	184	49	104	156	49	120	158
50	172	291	50	144	234	50	123	192	50	109	164	50	130	170
51	172	291	51	144	234	51	123	192	51	109	164	51	130	170
52	172	291	52	144	234	52	123	192	52	109	164	52	130	170
53	185	314	53	154	252	53	132	207	53	116	176	53	140	184
54	185	314	54	154	252	54	132	207	54	116	176	54	140	184
55	185	314	55	154	252	55	132	207	55	116	176	55	140	184
56	200	341	56	166	273	56	141	224	56	124	190	56	152	200
57	200	341	57	166	273	57	141	224	57	124	190	57	152	200
58	200	341	58	166	273	58	141	224	58	124	190	58	152	200
59	215	368	59	178	294	59	151	241	59	133	204	59	165	216
60	215	368	60	178	294	60	151	241	60	133	204	60	165	216
61	215	368	61	178	294	61	151	241	61	133	204	61	165	216
62	231	396	62	191	316	62	162	259	62	142	219	62	178	233
63	231	396	63	191	316	63	162	259	63	142	219	63	178	233
64	231	396	64	191	316	64	162	259	64	142	219	64	178	233
65+	346	600	65+	285	478	65+	241	390	65+	210	328	65+	273	358

Exhibit II

Special Indemnity Policy Form SIP-1

Regular Monthly Premium Rates / Tobacco

No Elimination Period			One Day Elimination Period			Two Day Elimination Period			Three Day Elimination Period			Surgery Rider		
Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$2,000	$3,000
0-17	85	125	0-17	75	106	0-17	68	92	0-17	63	82	0-17	58	76
18	121	192	18	103	158	18	91	133	18	82	116	18	72	92
19	121	192	19	103	158	19	91	133	19	82	116	19	72	92
20	121	192	20	103	158	20	91	133	20	82	116	20	72	92
21	121	192	21	103	158	21	91	133	21	82	116	21	72	92
22	121	193	22	104	159	22	91	133	22	82	116	22	72	92
23	126	203	23	108	166	23	95	140	23	85	121	23	79	102
24	127	204	24	108	167	24	95	140	24	86	122	24	79	102
25	127	205	25	108	167	25	95	140	25	86	122	25	80	102
26	131	211	26	111	173	26	97	144	26	87	125	26	89	116
27	131	212	27	111	173	27	98	144	27	87	126	27	89	116
28	131	212	28	111	174	28	98	145	28	87	126	28	90	117
29	137	222	29	116	182	29	101	151	29	91	130	29	94	122
30	137	223	30	116	182	30	101	152	30	91	131	30	94	122
31	137	223	31	116	183	31	102	152	31	91	131	31	94	123
32	143	234	32	121	190	32	105	159	32	94	137	32	98	128
33	144	236	33	122	192	33	106	160	33	94	138	33	99	129
34	145	238	34	123	193	34	107	161	34	95	139	34	99	130
35	149	246	35	126	200	35	110	166	35	98	143	35	104	135
36	150	248	36	127	201	36	110	167	36	99	144	36	105	136
37	151	250	37	127	203	37	111	168	37	99	145	37	106	137
38	159	263	38	134	213	38	116	177	38	103	152	38	112	146
39	162	267	39	136	217	39	118	180	39	104	154	39	113	148
40	164	271	40	138	220	40	119	182	40	106	156	40	115	150
41	172	286	41	144	230	41	124	191	41	111	164	41	121	158
42	174	289	42	146	233	42	126	194	42	112	166	42	122	160
43	176	294	43	148	237	43	128	196	43	114	168	43	124	162
44	188	315	44	157	254	44	136	210	44	120	179	44	134	175
45	191	320	45	159	258	45	137	213	45	122	181	45	136	177
46	193	323	46	161	261	46	139	215	46	123	183	46	138	180
47	204	344	47	170	277	47	147	229	47	129	194	47	149	196
48	207	349	48	173	281	48	149	232	48	131	197	48	151	199
49	209	353	49	175	285	49	151	235	49	133	199	49	153	202
50	222	376	50	186	302	50	159	248	50	141	212	50	168	219
51	225	380	51	188	306	51	161	251	51	142	214	51	170	222
52	227	384	52	190	309	52	162	254	52	144	217	52	172	224
53	246	418	53	205	336	53	176	276	53	155	234	53	186	245
54	248	422	54	207	338	54	177	278	54	156	236	54	188	247
55	250	425	55	208	341	55	179	280	55	157	238	55	189	249
56	273	465	56	226	372	56	192	305	56	169	259	56	207	273
57	274	468	57	228	375	57	193	307	57	170	261	57	209	274
58	274	468	58	228	374	58	193	307	58	170	261	58	209	274
59	295	505	59	244	403	59	207	331	59	182	280	59	226	296
60	295	505	60	244	403	60	207	331	60	182	280	60	226	296
61	295	505	61	244	403	61	207	331	61	182	280	61	226	296
62	317	543	62	262	433	62	222	355	62	195	300	62	244	320
63	317	543	63	262	433	63	222	355	63	195	300	63	244	320
64	317	543	64	262	434	64	222	355	64	195	300	64	244	320
65+	475	823	65+	391	656	65+	331	535	65+	288	450	65+	375	491

Exhibit II

Special Indemnity Policy Form SIP-1 / Preferred Risk

Regular Monthly Premium Rates / Nontobacco

No Elimination Period			One Day Elimination Period			Two Day Elimination Period			Three Day Elimination Period			Surgery Rider		
Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$2,000	$3,000
0-17	55	81	0-17	49	69	0-17	44	60	0-17	41	53	0-17	38	49
18	77	122	18	66	101	18	58	85	18	52	73	18	46	59
19	77	122	19	66	101	19	58	85	19	52	73	19	46	59
20	77	122	20	66	101	20	58	85	20	52	73	20	46	59
21	77	122	21	66	101	21	58	85	21	52	73	21	46	59
22	77	122	22	66	101	22	58	85	22	52	73	22	46	59
23	80	129	23	68	105	23	60	88	23	54	77	23	50	64
24	80	129	24	68	105	24	60	88	24	54	77	24	50	64
25	80	129	25	68	105	25	60	88	25	54	77	25	50	64
26	82	133	26	70	109	26	61	90	26	55	79	26	56	73
27	82	133	27	70	109	27	61	90	27	55	79	27	56	73
28	82	133	28	70	109	28	61	90	28	55	79	28	56	73
29	85	138	29	72	113	29	63	94	29	57	81	29	59	76
30	85	138	30	72	113	30	63	94	30	57	81	30	59	76
31	85	138	31	72	113	31	63	94	31	57	81	31	59	76
32	88	145	32	75	118	32	65	98	32	58	85	32	60	79
33	88	145	33	75	118	33	65	98	33	58	85	33	60	79
34	88	145	34	75	118	34	65	98	34	58	85	34	60	79
35	90	149	35	76	121	35	66	100	35	59	86	35	63	82
36	90	149	36	76	121	36	66	100	36	59	86	36	63	82
37	90	149	37	76	121	37	66	100	37	59	86	37	63	82
38	94	155	38	79	125	38	68	104	38	60	89	38	66	86
39	94	155	39	79	125	39	68	104	39	60	89	39	66	86
40	94	155	40	79	125	40	68	104	40	60	89	40	66	86
41	97	161	41	81	130	41	70	108	41	62	92	41	68	89
42	97	161	42	81	130	42	70	108	42	62	92	42	68	89
43	97	161	43	81	130	43	70	108	43	62	92	43	68	89
44	102	171	44	85	138	44	73	114	44	65	97	44	73	95
45	102	171	45	85	138	45	73	114	45	65	97	45	73	95
46	102	171	46	85	138	46	73	114	46	65	97	46	73	95
47	107	180	47	89	145	47	77	120	47	68	101	47	78	103
48	107	180	48	89	145	48	77	120	48	68	101	48	78	103
49	107	180	49	89	145	49	77	120	49	68	101	49	78	103
50	112	189	50	94	152	50	80	125	50	71	107	50	85	111
51	112	189	51	94	152	51	80	125	51	71	107	51	85	111
52	112	189	52	94	152	52	80	125	52	71	107	52	85	111
53	120	204	53	100	164	53	86	135	53	75	114	53	91	120
54	120	204	54	100	164	54	86	135	54	75	114	54	91	120
55	120	204	55	100	164	55	86	135	55	75	114	55	91	120
56	130	222	56	108	177	56	92	146	56	81	124	56	99	130
57	130	222	57	108	177	57	92	146	57	81	124	57	99	130
58	130	222	58	108	177	58	92	146	58	81	124	58	99	130
59	140	239	59	116	191	59	98	157	59	86	133	59	107	140
60	140	239	60	116	191	60	98	157	60	86	133	60	107	140
61	140	239	61	116	191	61	98	157	61	86	133	61	107	140
62	150	257	62	124	205	62	105	168	62	92	142	62	116	151
63	150	257	63	124	205	63	105	168	63	92	142	63	116	151
64	150	257	64	124	205	64	105	168	64	92	142	64	116	151
65+	225	390	65+	185	311	65+	157	254	65+	137	213	65+	177	233

Exhibit II

Special Indemnity Policy Form SIP-1 / Preferred Risk

Regular Monthly Premium Rates / Tobacco

No Elimination Period			One Day Elimination Period			Two Day Elimination Period			Three Day Elimination Period			Surgery Rider		
Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$1,000/day	$2,000/day	Attd Age	$2,000	$3,000
0-17	55	81	0-17	49	69	0-17	44	60	0-17	41	53	0-17	38	49
18	79	125	18	67	103	18	59	87	18	53	75	18	47	60
19	79	125	19	67	103	19	59	87	19	53	75	19	47	60
20	79	125	20	67	103	20	59	87	20	53	75	20	47	60
21	79	125	21	67	103	21	59	87	21	53	75	21	47	60
22	79	125	22	68	104	22	59	87	22	53	75	22	47	60
23	82	133	23	70	108	23	62	90	23	55	79	23	51	66
24	82	133	24	70	108	24	62	91	24	56	79	24	52	66
25	83	133	25	70	108	25	62	91	25	56	80	25	52	66
26	85	138	26	73	113	26	63	93	26	57	82	26	58	76
27	85	138	27	73	113	27	63	93	27	57	82	27	58	76
28	85	138	28	73	114	28	64	94	28	57	82	28	58	76
29	89	144	29	75	118	29	66	98	29	59	85	29	62	79
30	89	144	30	75	118	30	66	98	30	60	85	30	62	80
31	89	145	31	76	119	31	66	99	31	60	85	31	62	80
32	93	152	32	79	124	32	68	103	32	61	89	32	63	83
33	93	154	33	79	125	33	69	104	33	61	90	33	64	84
34	94	155	34	80	126	34	69	105	34	62	91	34	64	84
35	97	160	35	82	130	35	71	108	35	63	92	35	68	88
36	97	161	36	82	131	36	71	108	36	64	93	36	68	89
37	98	162	37	83	132	37	72	109	37	64	94	37	69	89
38	104	171	38	87	138	38	75	115	38	66	98	38	73	95
39	105	174	39	89	140	39	76	117	39	67	100	39	74	96
40	107	176	40	90	142	40	77	118	40	68	101	40	75	98
41	112	185	41	93	150	41	81	124	41	71	106	41	78	103
42	113	188	42	94	152	42	82	126	42	72	107	42	79	104
43	115	191	43	96	154	43	83	128	43	73	109	43	80	105
44	122	205	44	102	166	44	88	137	44	78	116	44	88	114
45	124	208	45	103	168	45	89	139	45	79	118	45	89	115
46	125	210	46	105	170	46	90	140	46	80	119	46	90	117
47	133	224	47	111	180	47	96	149	47	85	126	47	97	128
48	135	227	48	112	183	48	97	151	48	86	127	48	98	130
49	137	230	49	114	185	49	98	153	49	87	129	49	100	131
50	145	244	50	121	196	50	103	161	50	92	138	50	110	143
51	146	247	51	123	199	51	104	163	51	93	140	51	111	145
52	148	250	52	124	201	52	106	165	52	94	141	52	112	147
53	160	272	53	133	218	53	115	180	53	100	152	53	121	160
54	161	274	54	134	220	54	115	181	54	101	153	54	122	161
55	162	276	55	135	222	55	116	183	55	101	154	55	123	162
56	177	303	56	147	241	56	125	199	56	110	169	56	135	177
57	178	305	57	148	243	57	126	200	57	111	170	57	136	178
58	178	305	58	148	243	58	126	200	58	111	170	58	136	178
59	192	328	59	159	262	59	134	215	59	118	182	59	147	192
60	192	328	60	159	262	60	134	215	60	118	182	60	147	192
61	192	328	61	159	262	61	134	215	61	118	182	61	147	192
62	206	353	62	170	281	62	144	230	62	126	195	62	159	207
63	206	353	63	170	281	63	144	230	63	126	195	63	159	207
64	206	353	64	170	281	64	144	230	64	126	195	64	159	207
65+	309	535	65+	254	427	65+	215	348	65+	188	292	65+	243	320

SERFF Tracking Number:	*RNIC-125859625*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*40586*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SIP-1 Fixed Indemnity Policy*		
Project Name/Number:	*SIP-1 Fixed Indemnity Policy/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice
Review Status: Approved-Closed 10/17/2008
Comments:
Attachment:
SIP-1 Readability Certificate.pdf

Satisfied -Name: Application
Review Status: Approved-Closed 10/17/2008
Comments:
Attachment:
UAP-1 AR 1.09.pdf

Satisfied -Name: Outline of Coverage
Review Status: Approved-Closed 10/17/2008
Comments:
Attachment:
OC SIP-1 AR.pdf

Reserve National
INSURANCE COMPANY

6100 NORTHWEST GRAND BLVD
OKLAHOMA CITY, OKLAHOMA 73118-1082

READABILITY CERTIFICATION

FORM NUMBER: Form SIP-1 – Fixed Indemnity Policy

The words, sentences, and syllables of Form SIP-1 were counted to be used in the Flesch Readability Formula in order to determine the readability score of the form. Formal names, medical terms and words defined (implicitly or explicitly) in the policy/rider/endorsement were not counted.

WORDS:	3,687
SENTENCES:	234
SYLLABLES:	4,726

This resulted in a Flesch Readability score of 82.386.

Kyle D. Conrad

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel

C:FILING\READABI.DRD

Reserve National INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA
GENERAL A&H APPLICATION

AGENT CODE _____
MGR CODE _____

FOR HOME OFFICE USE ONLY

POLICY NUMBER(S):

EFFECTIVE DATE: Month | Day | Year

1. Full Name of Each Applicant

	First	Middle Initial	Last	Social Security No.	Relation To Proposed Insured	BIRTH DATE Mo.	Day	Yr.	Age	Ht.	Wt.	Sex
1					Proposed Insured							
2												
3												
4												

Check policy/policies applied for (availability of policies varies by state):

❑ Scheduled Benefit Hospital, Medical, Surgical Expense Policy RN-50
❑ Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1
❑ Limited Benefit Hospital and Surgical Expense Policy LHS
❑ Scheduled Benefit Accident-Only Policy SA-1

Benefit % | Deductible $ | Daily Room Max. $ | Hospital Misc. Max. $

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

❑ Supplemental First Diagnosis Heart Attack and First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) $_____
First Major Heart Surgery Benefit (after 30 days) $_____

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

Accident Policy
❑ AP-79 ❑ AP-02-79
❑ AP-91 ❑ AP-91-70

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Medicare Supplement Policy
Standard Plan _____

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

Supplemental Outpatient Expense Policy Deductible $_____
❑ OS-99 ❑ OP-2000

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

Total _____

❑ Hospital Indemnity Policy HDI ❑ Fixed Indemnity Policy SIP-1*
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

App't #	Basic Mthly. Rt.	List Endorsements & Rates				PEB Table	Total Monthly Premium
1							
2							
3							
4							

***Elimination Period Before Daily Indemnity is Payable: _____ Days**

Total _____

❑ Home Health Care
Indemnity Policy HHC-95

App't #	Basic Mthly. Rt.	List Endorsements & Rates				Total Monthly Premium
1						
2						
3						
4						

Total _____

Cancer Policy
❑ CFO-95-First Occurrence Cancer Benefit After 180 Days $_____
❑ CC-74 ❑ CC-91

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	
2	
3	
4	

Total _____

❑ Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death $_____

App't #	Total Monthly Prem.	PEB Table
1		

Total _____

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
Street No. / Rural Route and/or Box Number City State Zip Code

3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____

3.(a) E-mail address _____ **3.**(b) Name, Address and Telephone No. of payor, if different from above _____

3.(c) Each Applicant's State of Birth _____

4.(a) Applicant's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____

5. Full Name of Beneficiary(ies) and Relationship _____

Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.

6. If submitted for purposes other than a new insurance application, please indicate: ❒ Policy Change ❒ Conversion ❒ Reinstatement:
Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

7. If this application is for a Medicare supplement, are applicant(s) enrolled in Medicare Part A? ❒ **Yes** ❒ **No** Part B? ❒ **Yes** ❒ **No**
If yes, enrollment date(s) _____
If no, which applicant(s)? _____

8. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

9. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application for insurance? ❒ **Yes** ❒ **No** If yes, which applicant(s), company and amount? _____
_____ (Complete replacement of insurance form.)

THE FOLLOWING QUESTIONS, #10 - #48, ARE TO BE ANSWERED WITH RESPECT TO EACH APPLICANT LISTED ABOVE. HOWEVER, THESE QUESTIONS ARE NOT REQUIRED FOR AN APPLICANT WHO IS APPLYING FOR ONLY A MEDICARE SUPPLEMENT WITHIN 6 MONTHS AFTER THE FIRST DAY HE/SHE IS 65 OR OLDER AND ENROLLED IN PART B.

10. Has any applicant smoked tobacco or used tobacco orally within the past year? ❒ **Yes** ❒ **No** Within the past 3 years? ❒ **Yes** ❒ **No**
If either are yes, which applicant(s)? _____

11. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly scheduled airline? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

12. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing, scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or semi-professional athletics? ❒ **Yes** ❒ **No** Which applicant(s) and details? _____

13. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? ❒ **Yes** ❒ **No** Which applicant(s) and details? _____

14. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not re-newed? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

15. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

16. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

17. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or appliance? ❒ **Yes** ❒ **No** If yes, which applicant(s) and details? _____

18. Is any applicant using any medication or drugs? ❒ **Yes** ❒ **No** If yes, which applicant(s) and name of medication? _____

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

19. Disorder of eyes, ears, nose, throat or glands? ... ❒ **Yes** ❒ **No**
20. Dizzy or fainting spells, seizures or convulsions or recurrent headache? ... ❒ **Yes** ❒ **No**
21. Paralysis, transient ischemic attack, stroke, cerebrovascular disease or insufficiency or hemorrhage, or any residuals thereof? ❒ **Yes** ❒ **No**
22. Mental, nervous, psychiatric disorder ... ❒ **Yes** ❒ **No**
23. Senility disorder, Alzheimer's disease, organic brain syndrome or disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease, neurologic or muscular wasting disease? ... ❒ **Yes** ❒ **No**
24. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, allergies, emphysema, tuberculosis, pneumonia or other lung or respiratory disorder(s)? ... ❒ **Yes** ❒ **No**

(Continued at top of next page)

25. Chest pain, discomfort or tightness, any heartbeat abnormality, abnormal EKG, rheumatic fever, heart murmur, heart attack or other disorder of the heart? ..... ❒ **Yes** ❒ **No**

26. Hypertension, high blood pressure, high cholesterol, carotid artery disease, coronary artery disorder, blood clot(s) or any other disorder of blood vessels? ..... ❒ **Yes** ❒ **No**

27. Has any applicant been advised by a physician or other practitioner to have any form of heart surgery, coronary artery surgery, arteriogram, angioplasty or pacemaker? ..... ❒ **Yes** ❒ **No**

28. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, esophageal reflux, or other disorder of the stomach, intestines, liver, hepatitis type B or C, gall bladder, pancreas or hemorrhoids? ..... ❒ **Yes** ❒ **No**

29. Sugar or blood in urine, end stage renal failure, stone or other disorder of kidney, bladder, prostate or reproductive organs? ..... ❒ **Yes** ❒ **No**

30. Diabetes or high blood sugar? ..... ❒ **Yes** ❒ **No**
If yes, which applicant(s) and age of onset? _____

_____

31. Thyroid or other endocrine disorders? ..... ❒ **Yes** ❒ **No**

32. Neuritis, sciatica, rheumatism, arthritis, gout, osteoporosis, or disorder of the muscles, ligaments, bones or joints, spine, back or disk disorder? ..... ❒ **Yes** ❒ **No**

33. Deformity, lameness, amputation or disabling injury? ..... ❒ **Yes** ❒ **No**

34. Disorder of the skin? ..... ❒ **Yes** ❒ **No**

35. Disorder of the lymph glands, unexplained fevers, cyst, tumor, cancer (including leukemia, Hodgkin's disease or lymphoma) or malignant neoplasm? ..... ❒ **Yes** ❒ **No**

36. Anemia, polycythemia vera, thrombocytopenia or other disorder of the blood? ..... ❒ **Yes** ❒ **No**

37. Have you or any applicant ever been diagnosed as having or been treated for AIDS, ARC (AIDS Related Complex), an immune deficiency disorder, HIV or any test results indicating exposure to the AIDS virus? ..... ❒ **Yes** ❒ **No**

38. Any sexually transmitted disease including syphilis, gonorrhea, herpes, chlamydia or condyloma acuminata (anal or genital warts)? ..... ❒ **Yes** ❒ **No**

39. Has any applicant sought or received advice or treatment for use of alcohol or drugs? ..... ❒ **Yes** ❒ **No**

40. Has any female ever had any disorder or complications of menstruation, pregnancy, childbirth, the female organs or breasts? ..... ❒ **Yes** ❒ **No**

41. Is any applicant now pregnant? ..... ❒ **Yes** ❒ **No**

42. Other than above, in the last 5 years, has any applicant been examined, advised or treated by any physician or practitioner? ..... ❒ **Yes** ❒ **No**

43. In the last 5 years, has any applicant been a patient in a hospital, clinic, psychiatric clinic or other medical facility? ..... ❒ **Yes** ❒ **No**

44. Has any applicant ever had an EKG, X-ray, CT scan, MRI or other test? ..... ❒ **Yes** ❒ **No**

45. Has any applicant lost or gained weight in the past 12 months? ..... ❒ **Yes** ❒ **No**
If yes, state amount and cause of loss or gain and indicate which applicant(s)_____

_____

46. Has any applicant been advised not to donate or been refused to donate blood? ..... ❒ **Yes** ❒ **No**
If yes, which applicant(s) and explain why and by whom below.

47. Has any applicant ever had or been advised by a physician or other practitioner to have any type of organ transplant? .. ❒ **Yes** ❒ **No**

48. Other than above, in the last 5 years, has any applicant had any mental or physical disorder, checkup, consultation, illness, injury, surgery, been a patient in a hospital, clinic, sanatorium or other similar facility or been advised to have any hospitalization, surgery, biopsy, testing or treatment which was not completed, or had any departures from good health not mentioned above? ..... ❒ **Yes** ❒ **No**
If yes, give full details in Question #49 below.

49. EXPLAIN YES ANSWERS TO QUESTIONS 19-48. (Attach additional page(s) if needed.)

Applicant No.	Disease or Ailment	Treatment Received	Dates Treated For	Present Status of Ailment	Full Name and Address of Attending Physician

Personal Physician _____ Medical Designation _____ Phone Number (____)_____

Address _____ City _____ State _____ Zip Code _____

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(Continue explanations at top of next page if necessary)

To enroll in the E-Z Way pre-authorized payment plan for renewal premiums, check the monthly or quarterly payment box, sign and date the authorization, and return with a voided personal check. Not available for initial premium.

Through the E-Z Way plan, your bank will pay your future **renewal** premiums from your checking account. The E-Z Way plan will eliminate the necessity of writing a check.

To take advantage of this convenient plan, simply complete the right-side portion of this form. On your next billing date, the premium will be paid by your bank. The payment will be reflected in your bank statement.

THE E-Z WAY PLAN AUTHORIZATION

TO RESERVE NATIONAL INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Reserve National Insurance Company, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

❒ **MONTHLY PAYMENT... or ❒ QUARTERLY PAYMENT**

_____ X _____

Date **Your signature EXACTLY as it appears on Bank Records**

FOR USE IN **ARKANSAS** ONLY

(Explanations continued from previous page)

_____

_____

_____

_____

_____

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, **I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company or MIB, INC. ("MIB"), that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed.**

I have paid to Reserve National Insurance Company the sum of $ _____ **which is a** ❒ Monthly ❒ Quarterly ❒ Semi-Annual ❒ Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. ❒ Date of application, applicable only on quarterly or longer modes. B. ❒ Date of issue C. ❒ Other _____

❒ SEND POLICY TO APPLICANT OR ❒ AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made. ..... ❒Yes ❒No.

I am 65 years old or older, or eligible for Medicare, and acknowledge receipt of a "**Guide to Health Insurance for People with Medicare.**"..... ❒Yes ❒No.

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS A SCHEDULED BENEFIT POLICY WITH LIMITS FOR EACH COVERED EXPENSE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE THERE ARE LIMITATIONS ON THE AMOUNT OF BENEFITS PAYABLE FOR EACH COVERED EXPENSE.

Town and State where signed_____ this _____ day of _____ , _____

_____ _____

Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured/Applicant

The undersigned agent (a) represents Reserve National Insurance Company in connection with the insurance applied for; (b) will receive compensation from the Company if coverage is issued; and (c) may provide services to policyholders on behalf of the Company, subject to the Company's approval. The agent does not have authority to bind the Company.

I certifiy that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____

Signature of Agent

UAP-1 AR (1/09)

Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my: ❒ VISA ❒ MasterCard ❒ DISCOVER NOVUS

ACCOUNT# AS SHOWN ON CARD

				–					–					–				

EXPIRATION DATE_____

PLEASE SELECT

❒ Please charge my credit card for the initial premium.

Amount authorized $_____

❒ Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: ❒ Monthly Payment ❒ Quarterly Payment

AUTHORIZED SIGNATURE _____

(PLEASE SIGN HERE)

NAME OF CARDHOLDER _____

(PLEASE PRINT NAME AS SHOWN ON CARD)

DATE AUTHORIZED_____

Reserve National
INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

"SELECT INDEMNITY POLICY"

THIS IS A FIXED INDEMNITY POLICY, WHICH PROVIDES STATED BENEFITS THAT ARE NOT DESIGNED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

Reserve National Insurance Company is hereinafter referred to as "we," "us" or "our." The individual(s) covered under the Policy are referred to as "you," "your" or "Covered Person."

1. Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of "Select Indemnity Policy" Form SIP-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

2. Fixed Indemnity Coverage is designed to provide coverage in the form of a stated indemnity benefit for covered treatment of a covered Injury or Sickness, subject to all the Policy's conditions, limitations and exclusions. Coverage is not provided for any benefits other than the fixed indemnity benefits described below. THIS IS A LIMITED POLICY. THIS POLICY IS NOT TO REPLACE EXISTING MAJOR MEDICAL COVERAGE, BUT MAY BE USED TO SUPPLEMENT MAJOR MEDICAL COVERAGE.

3. HOSPITAL CONFINEMENT BENEFIT: If a Covered Person is confined in a Hospital as a resident inpatient as a result of an Injury or Sickness, we will pay, beginning with the first day of Hospital confinement following the Elimination Period, the following Hospital Confinement Benefit for each day of confinement, **limited to** the Maximum Hospital Confinement Benefit Period of **31 days for each Policy Year:**

(a) Elimination Period (must be satisfied each Policy Year): _____ day(s)

(b) For the first 10 full days of Hospital confinement after the Elimination Period: $ _____ per day

(c) For the next 21 full days of Hospital confinement: $ _____ per day

A "day" is a 24-hour period. No benefit is payable for a partial day of Hospital confinement.

4. INPATIENT DOCTOR VISITS BENEFIT: If a Covered Person is confined in a Hospital as a resident inpatient as a result of an Injury or Sickness, we will pay the Inpatient Doctor Visits Benefit in the amount of $75.00 for each day the confined Covered Person receives personal treatment by a Physician, limited to 10 visits in a Policy Year. Each Covered Person is limited to one Benefit for Inpatient Doctor Visits for each day he/she receives personal treatment by one or more Physicians while confined in a Hospital.

5. OUTPATIENT DOCTOR VISITS BENEFIT: If a Covered Person receives personal treatment by a Physician in the Physician's office or a clinic, as a result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Benefit in the amount of $65.00 per visit, limited to one visit per day, and not to exceed two visits in a Policy Year.

6. PRESCRIPTIONS, X-RAYS AND LAB TESTS BENEFIT: If a Covered Person incurs expense for Prescription Drugs, X-Rays or laboratory tests, as the result of an Injury or Sickness, we will pay $50.00 for each Prescription Drug, X-Ray or laboratory test, limited to a maximum aggregate benefit of $250.00 for all Prescription Drugs, X-Rays and laboratory tests per Policy Year.

7. HOME HEALTH CARE BENEFIT:

Home Health Care Benefit

Daily Maximum Aggregate Benefit ..... up to $150.00

Home Health Care Services:

Skilled Nursing Care (provided by a licensed graduate nurse [R.N.]) $75.00

General Nursing Care (provided by a licensed practical nurse [L.P.N.], licensed vocational nurse [L.V.N.] or licensed visiting nurse) $60.00

Physical Therapy $75.00

Speech Pathology $75.00

Occupational Therapy $75.00

Chemotherapy Specialist Services $60.00

Enterostomal Therapy $50.00

Respiration Therapy $50.00

Medical Social Services $100.00

Home Health Care Aide Benefit

Daily Benefit $40.00

Maximum Benefit Periods: The Maximum Benefit Period for the Home Health Care Benefit is 100 days, and the Maximum Benefit Period for the Home Health Care Aide Benefit is 60 days. The Maximum Benefit Period is the maximum number of days we will pay benefits during your lifetime, unless benefits are restored as provided in the Restoration of Benefits provision.

Restoration of Benefits: The original Maximum Benefit Periods for the Home Health Care Benefit and the Home Health Care Aide Benefit will be restored if benefits have not been paid or required for 180 consecutive days.

(a) HOME HEALTH CARE BENEFIT: We will pay a daily benefit each day you require Home Health Care provided by an Approved Home Health Care Practitioner, subject to the eligibility conditions below. The amount of the daily benefit for all Home Health Care Services for any one day will be the lesser of: (i) the Dally Maximum Aggregate Benefit shown above or (ii) the amount set forth opposite the Home Health Care Services listed above.

(b) HOME HEALTH CARE AIDE BENEFIT: Immediately following a Hospital confinement of not less than three days, we will pay a daily benefit of $40.00 for each day you require the services of a Home Health Care Aide in Your Home.

Conditions on Eligibility for the Home Health Care Benefit and the Home Health Care Aide Benefit: Payment of the Home Health Care Benefit and the Home Health Care Aide Benefit is subject to the following:

(1) Your loss must be incurred after the Policy's effective date and while the policy is in force;

(2) For the Home Health Care Benefit, care must be provided in Your Home by an Approved Home Health Care Practitioner, as defined in the Policy; and for the Home Health Care Aide Benefit, care must be provided by in Your Home by a Home Health Care Aide, as defined in the policy; and

(3) You must be unable to perform, without the assistance of another person, two or more Activities of Daily Living (ADL's); or you must require continuous supervision and assistance due to a Cognitive Impairment. To meet this requirement, your Physician must perform such tests as are in accordance with accepted standards of medical practice and, based on such tests, certify in writing that you are unable to perform two or more ADL's or that you have a Cognitive Impairment. ADL's are bathing, dressing, eating, toileting and transferring to or from a bed or a chair.

8. _____(applicant's initials to select) OPTIONAL SURGICAL BENEFIT RIDER:

(a) SURGEON'S BENEFIT: If a Covered Person has a surgical procedure performed by a Physician as a result of an Injury or Sickness, we will pay the applicable amount shown on the Schedule of Surgical Operations in the Policy. The maximum aggregate benefit payable for all surgical operations shall be limited to $_____ in any Policy Year. This benefit is payable for either inpatient or outpatient surgery.

(b) ANESTHESIA BENEFIT: If a Covered Person has a surgical operation performed by a Physician as a result of an Injury or Sickness, and is administered anesthesia during the surgical operation, we will pay 25% of the applicable amount payable under the Surgeon's Benefit.

(c) OUTPATIENT SURGICAL FACILITY BENEFIT: If a Covered Person has a surgical operation as a result of an Injury or Sickness for which Surgery Benefits under the Policy are payable, which is performed on an outpatient basis in a Hospital, ambulatory surgical center, licensed clinic, Physician's office or any other facility appropriately licensed for the performance of outpatient surgery, we will pay the Outpatient Surgical Facility Benefit in the amount of $500.00.

9. EXCLUSIONS: The Policy does not cover any loss caused or contributed to by: (a) Injury or Sickness sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by the Policy while you are in such service); (b) suicide or attempted suicide, while sane or insane, or any intentionally self-inflicted Injury; (c) drug abuse, drug overdose or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) Injury or Sickness covered by any worker's compensation act, occupational diseases law or any motor vehicle no-fault law; (g) dental care or treatment, **except** that excluded dental care or treatment shall not include (1) reconstructive surgery when such service is incidental to trauma or (2) treatment of accidental Injury to whole natural teeth received within six months following an accident; (h) cosmetic or elective surgery (including surgery to correct myopia, hyperopia, presbyopia or astigmatism and surgery for weight loss or modification), **except** that excluded cosmetic surgery shall not include (1) reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, (2) reconstructive surgery because of congenital disease or anomaly of an insured dependent child which has resulted in a functional defect or (3) breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed; (i) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (j) childbirth; (k) participation in a felony or attempted felony, riot or insurrection; (l) rest cures, custodial care, and routine physical examinations; (m) surgical sterilization; (n) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (o) eye glasses, hearing aids and examination for the prescription or fitting thereof.

10. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of 12 months; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of loss. "Pre-existing condition" means a condition that has been diagnosed, or has manifested itself to you within the 12-month period immediately preceding the Effective Date of the Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the 12-month period following the Effective Date of the Policy.

11. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, in the date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Policy's Coverage for Spouse and Dependent Children provision.

12. RENEWAL SAFEGUARD: The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

(1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or

(2) Failure to correctly report matters inquired of in the application for the Policy.

(b) **While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.**

13. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status and state of residence. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.
IT PROVIDES THE FIXED INDEMNITY BENEFITS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

PLEASE READ BEFORE SIGNING

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

I understand and acknowledge that:

•Form SIP-1 provides limited benefits; it is not a major medical policy.

•I have received a copy of this outline of coverage, which I have reviewed.

Dated this _____day of _____, 20_____.

Signed at _____, State of _____.

_____
Applicant's Signature

_____ _____
Agent's Signature Date

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.] "Select Indemnity Policy" Form SIP-1 is individually underwritten by Reserve National Insurance Company.